STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit for a Recertification and State Licensure Survey. Survey dates: June 11, 12, 13, 14, 15, 16 and 18, 2012 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Survey team: Marcy Smith, RN-TC Dinah Jones, RN Patti Allen, BSW Leia Alley, RN (June 11, 12, 13, 14, 15, 2012) Census bed type: SNF: 18 SNF/NF: 104 Total: 122 Census payor type: Medicare: 28 Medicaid: 48 Other: 46 Total: 122 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2. Quality review completed on June 20,	F0000	Kim Rhoades, Director Long Term Division Indiana State Department of Health 2 North Meridian Street Indianapolis, Indiana 46204 Subject: Greenwood Meadows Annual Survey Plan of Correction (Provider Number 155788) Request for a Desk Review for a Paper Compliance Revisit. Dear Ms. Rhoades, On June 18 th , 2012 representatives of the Indiana State Department of Health concluded the annual licensure and certification survey at this property. We respectfully request this document submitted as the Plan of Correction be considered for a desk review of the survey by the staff of your division. If any questions arise regarding this request or attached documents please feel free to contact me at your earliest convenience. Respectfully submitted: Ginger L. Fitzpatrick, H.F.A., Executive Director Cc: Chris Shuey, Director of Operations Sue Hornstein, Director of Compliance Martha Herron, Director of Clinical Services file	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review and interview, the facility failed to provide notification of liability and appeal notices to 3 of 6 residents reviewed for Medicare beneficiaries receiving Notice of Medicare Non Coverage. Resident #s 26, 20, and 6. Findings Include: Resident # 26, #20 and #6 closed, discharged records were reviewed on 6/12/12 at 10:00 a.m. Resident #26 was discharged on 2/4/12. There was no information	F0156	We respectfully request a desk review in lieu follow up survey. This document should serve as a credible letter of compliance for this facility. F156 It is the intent of this community to inform residents, and families of their rights and responsibilities both orally and in a written form via the Notice of Medicare Non-Coverage (NOMNC). **What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Date of Completion 7/1/12** The Facility will send the Notice of Medicare Non-Coverage (NOMNC) CMS 10095 to residents that have been identified in this survey. The facility has completed a Continuous Quality Improvement (CQI) Audit of the most recent discharges from therapy with	07/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicating Resident #26 received his Medicare Non Coverage Notice prior to his discharge. Resident #20 was discharged on 3/20/12. There was no information indicating Resident #20 received his Medicare Non Coverage Notice prior to his discharge. Resident #6 was discharged on 2/8/12. There was no information indicating Resident #6 received his Medicare Non Coverage Notice prior to his discharge. Information regarding Residents # 26, #20 and #6, Notice of Medicare Non Coverage forms was requested from the Business Office Manager (B.O.M.) on 6/12/2012 at 10:45 a.m. During an interview with the B.O.M., 6/12/12 at 11:20 a.m, the B.O.M. indicated she was unable to find the notices. She indicated that she is new to her position and is not sure of where the former B.O.M. placed them. The B.O.M. provided information for three other residents		100% accuracy. (See Exhibit A) **How will you identify other Residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by this alleged practice. Residents that are discharging from therapy services have the immediate impact of this deficiency. **What measures will you put in place or what systematic changes you will make to ensure that the deficient practice does not recur?** Social Services Director and Business Office Manager were individually in-serviced with Notice of Medicare Non-Coverage Requirements. (See Exhibit B) These individuals were also given a Post Test after the in-service to ensure knowledge was obtained. (See Exhibit C) Social Services Director or Designee will attend Medicare Meeting to identify residents that will be discharging from Medicare Part A and Part B services. Social Services Director or Designee will fill out the NOMNC during the meeting once the individuals are identified. Rehab Services Manager or Designee will alert Social Services during meeting that will be discharging in the next so that NOMNC can be completed prior to discharge. Social Services Director or Designee will have the resident sign the NONMC prior to discharge. **How the corrective**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that she had provided the Medicare Non Coverage Notice. She indicated she would continue to search for the missing records. 3.1-4(f)(3)		**action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The initial monthly Continuous Quality Improvement (CQI) was completed of the 10 most recent discharges from therapy services with 100% accuracy results achieved. A CQI will be completed each month for the next 12 months. (See Exhibit D) Results will be maintained and submitted for review at the monthly CQI meeting.. Results will be reviewed by its members including the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure residents received their food in a timely and dignified manner. This practice affected 9 residents observed during 2 of 2 dining observations and 2 residents whose family members were interviewed. This had the potential to affect all 21 residents needing assistance with their meals in the assisted dining room. (Residents #205, 115, 51, 151, 23, 63, 67, 158, 70, 50 and 126) Findings include: 1. During an observation of the lunch meal on 6/12/12 at 11:21 a.m., Resident #205, #115 and #51 were seated at a table with LPN #2. RN #1 was standing next to this table and indicated to LPN #2 "I'll go get some more bibs." 2. During an observation of the lunch meal on 6/13/12 at 10:49 a.m., the following was observed:	F0241	**F 241** It is the practice of this provider to ensure that all resident's meals are served in a dignified fashion and that the dining experience enhances self-esteem and self-worth. This program is designed to promote individual choices in dining experiences by including all residents in the culture change experience. Residents in the assisted program are offered the same fine dining experience and choices. (See Exhibit E). This programming is designed to encourage residents to place orders to honor individual choices from a menu which has multiple selections with many food items prepared cooked to order just as one would experience in a restaurant setting. Early morning the Café has a Continental Breakfast Bar available for early risers at 6:00 am. Serving hours for the Fine Dining experience encompasses two hours at each meal time that residents may come and go as personal choice dictates. The breakfast meal is individually selected according to each resident preference's and cooked to order. Menu choices for the midday and evening meal	07/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #67 was sitting at his table at 10:49 a.m. His food was brought to him at 11:46 a.m. He waited 57 minutes for his meal to be served. He requested coffee at 11:06 and 11:11. Coffee was brought to him at 11:17. He was not observed interacting with other residents at his table. Review of an MDS (Minimum Data Set) (an assessment instrument), dated 4/10/12, indicated his cognition and decision making abilities were moderately impaired and he was totally dependent on staff to go from one location to another in his wheelchair. Resident #158 was brought to the dining room by his wife at 10:50 a.m. His food was brought to him at 11:40 a.m. He waited 50 minutes for his meal to be served. Review of an MDS, dated 4/11/12, indicated his cognition and decision making abilities were severely impaired and he needed extensive assistance from staff to go from one location to another in his wheelchair. Resident #126 was brought to the dining room by CNA (Certified Nursing Assistant) #4 at 10:50 a.m. His food was brought to him at 11:40 a.m. He waited 50 minutes for his meal to be served.		services include a Chef's Special or ala carte options with many made to order selections. Residents requiring assistance are always supervised and assisted by a licensed nurse and provided with beverages while waiting for individual orders to be taken and food choices prepared. (See Exhibit F) The residents of this facility are encouraged to come to the dining room at the time convenient for them and all residents are invited to enjoy this program and if they need assistance are asked if they wish to come to the Café (Fine Dining Program) each meal service. Other dining areas are available to select from if a resident prefers. **Date of Completion: 7/1/2012 What corrective action will be accomplished for those residents found to have been affected by this deficient practice (Residents #205,115,51,151,23,63,67,158,70 ,50 and 126)** The assisted residents will be assigned a specific time to be taken to the dining room (7:30 am, 11:30 am and 5:30pm) Residents and guests will be advised that this is the time serving will begin for this group of residents. An individual server will be assigned to these residents upon arrival to take individual meal orders Beverages of choice are served by the licensed nurse in attendance as the residents orders are being taken by the server Soup and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of an MDS, dated 5/3/12, indicated his cognition and decision making abilities were severely impaired and he needed extensive assistance from staff to go from one location to another in his wheelchair. Resident #23 was brought to the dining room by CNA #3 at 11:07 a.m. Her food was brought to her at 11:52 a.m. She waited 45 minutes for her meal to be served. Review of an MDS, dated 4/7/12, indicated her cognition and decision making abilities were severely impaired and she was totally dependent on staff to go from one location to another in her wheelchair. Resident #63 was brought to the dining room by CNA #4 at 11:07 a.m. At 11:25 a.m., she indicated "Where's my food." Her food was brought to her at 11:53 a.m. She waited 47 minutes for her meal to be served. Review of an MDS, dated 3/9/12, indicated her cognition and decision making abilities were severely impaired. Resident #151 was brought to the dining room by CNA #3 at 11:12 a.m. Her food was brought to her at 11:52 a.m. She waited 40 minutes for her meal to be served.		salad selections will be delivered while the main entrée is being prepared to order as requested Meal will be served after preparation Dessert selections will be delivered after the main entrée is finished **How will you identify other residents having the potential to be affected by this deficient practice and what corrective action will be taken?** Residents are consistently assessed for assistance needed in all areas of care each shift by the licensed charge nurses during report, rounds, changes in condition and delivery of patient care Any resident needing assistance with transportation to meal service will continue to be invited to the Café Fine Dining Service while offered alternative dining program locations Individual choices will be honored Assisted dining experience times have been changed to begin at a specific time and staff will continue to be in attendance to assist, take orders and serve Staff reorganization has been implemented with assignments clearly defined for specific areas (tables) of the dining room Nursing staff have been advised of the proper time to transport these residents to the dining program , unless the resident specifically requests to come at a different time Nurses' aide assignment sheets have been updated for the assisted residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She was not observed interacting with the other resident sitting at her table. Review of an MDS, dated 3/23/12, indicated her cognition and decision making abilities were severely impaired and she needed assistance from staff to go from one location to another. During an interview with Dietary Aide #5 on 6/15/12 at 8:30 a.m., she indicated the assisted dining room has 7 tables with approximately 3 residents at each table during the lunch meal. On 6/15/12 at 2:00 p.m., the Registered Dietician was interviewed about the above residents having to wait for so long for their food to be served. She indicated at this time "They shouldn't have to wait that long." During an interview with the Assistant Administrator (A.A.) and Director of Nursing (DON) on 6/15/12 at 4:00 p.m., they indicated they felt it was alright for residents to be brought to the assisted dining room early because it was a change of scenery for them and they could interact with the other residents at their tables. The A.A. and DON indicated at this time they try to serve meals on a first		to communicate this information Staff Development Coordinator provided education on F241 and the Resident Meal Service Program completed on 6-29-12. (See Exhibit G) Failure to comply with the education provided to serve these residents in a timely manner will result in disciplinary counseling by the immediate supervisor, documented in the personnel record , up to and including termination. Registered Dietician/Director of Nursing Service/Licensed Nursing Managers are responsible for monitoring meal service delivery during observations on a regularly scheduled basis. **What measures are put into place for what systemic changes will be made to ensure that the deficient practice does not recur?** Specific table assignments have been made for the waitress' and licensed nursing staff to take orders for individually ordered meals and choice of beverages upon arrival to the dining area Dietary staff will process these orders while the residents choice of soup and/ or salad is being served Specific time has been established for the assisted residents to arrive in the dining area and nurses' aide assignment sheets have been updated. Residents will continue to be given a choice of dining service areas and programs available to participate in. Facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	come first serve basis and they try to serve everyone at a table at the same time. The A.A. indicated "Of course, we always ask the residents first if they want to go to the dining room." During an interview with the wife of Resident #70 on 6/13/12 at 3:54 p.m., she indicated she often eats with her husband in the assisted dining room and they often have to wait a long time for the meal to be served, "Sometimes an hour or more." She indicated "It seems like the residents who come into the unassisted part of the dining room get served much faster." During an interview with the wife of Resident #50 on 6/14/12 at 11:00 a.m., she indicated she often eats with her husband in the assisted dining room and they often have to wait a long time for the meal to be served. An undated facility policy, received from the Assistant Administrator on 6/16/12 at 9:05 a.m., titled "Greenwood Meadows Dining Services," indicated "Goal: Provide residents with a fine dining experience in an enjoyable atmosphere...Meal Service Times...Lunch 11:00 - 1:00 p.m....The		personnel have been in-serviced by the Staff Development Coordinator on F241 Dignity and Respect of the Individuality and enhancement of each residents choices. (See Exhibit H) Nurses' aide assignment sheets are updated with each residents dining area choice and time of service so residents whom require assistance with transportation will be escorted to meal service at the time service begins Personnel have been assigned specifically to the assisted residents to take meal orders upon arrival to the dining area Beverages will be served upon seating with soup and/or salads will be promptly delivered after resident has ordered his/her meal so the meal can begin while individual orders are prepared Assigned dining managers will monitor food service at each meal service **How will the corrective action(s) be monitored to ensure the deficient practice will not recur:** CQI audit will be used as a monitoring tool. (See Exhibit I) This tool will be completed daily x7, weekly x4, monthlyx2 and then on a quarterly basis for 2 quarters. If the threshold of 95% are not met, the results will be reviewed by the CQI committee and an action plan will be developed and implemented. The CQI tool will be monitored by the Director of Nursing Service and Registered Dietician at scheduled Food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	goal of our dining program is to resemble a fine dining restaurant. Residents will receive drink orders upon arrival, followed by a soup or salad option prior to their meal service..." 3.1-3(t)		Service meetings'.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a resident's blood pressure was within physician ordered parameters prior to giving blood pressure medications for 1 of 10 residents reviewed for unnecessary drugs from 20 who met the criteria of unnecessary drugs and failed to ensure blood sugar checks were performed as ordered during prednisone therapy for 1 of 4 residents of the 20 who met the	F0329	**F329** It is the practice of this provider to ensure that each residents' prescribed medication is adequately monitored and that documentation of this practice is completed by the licensed nurses responsible for this practice. **Date of Correction: 7/1/2012** **What corrective action will be accomplished for those residents found to have been affected by this deficient practice (Residents #41 and 46).** The lack of documentation did not result in any negative outcome or change in condition	07/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	criteria for review. (Resident #41 and 46) Findings include: 1. The record of Resident #41 was reviewed on 6/13/12 at 2:15 p.m. Diagnoses for Resident #41 included, but were not limited to, high blood pressure and dementia. Review of the recapitulated physician orders for April, 2012, indicated Resident #41 was to receive Atenolol 50 milligrams (mg) and Diltiazem 240 mg every morning with the original order date 10/27/11. These are medications used for treating high blood pressure. Review of a physician's order, dated 3/30/12, indicated the medications were not supposed to be given if the resident's blood pressure was less than or equal to 100/70. Review of a Medication Administration Record (MAR) for April, 2012, for Resident #41, indicated the following: on April 6, 9, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 2012, Atenolol 50 mg and Diltiazem 240 mg were given to Resident #41. No blood pressures		for the resident #41 and #46 A medication incident report was completed and the attending physician notified of this lack of documentation for each resident The specific nurses that did not complete this documentation have received written counseling performance reports. The nurses identified have been provided with one to one education and have been evaluated by a nursing manager for medication administration and documentation (See Exhibit J) Both resident #41 and Resident #46 medical records are being audited by the Unit Managers to identify any lack of following documentation practice immediately **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents residing in the facility who are being monitored for Blood Pressure/Blood Sugars have the potential to be affected by this alleged deficient practice Residents who need to be assessed for these conditions will be identified and instructions included on the residents MAR to be monitored by licensed nurses according to physician orders **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were documented in the resident's record as being taken prior to administration of her blood pressure medication. This same MAR indicated on April 4 and 19, 2012, the resident's blood pressure medications were held. No blood pressures were documented in the resident's record prior to the blood pressure medications being held. On 6/15/12 at 11:51 a.m., the Director of Nursing provided "24 hour" sheets. Some of the above missing blood pressures for Resident #41 had been written on these sheets, but no time was documented to indicate if the blood pressures had been taken prior to administering or holding the medications. Review of nursing notes, dated 4/24/12, indicated a new physician's order had been received to hold Resident #41's blood pressure medications related to decreased blood pressure. Review of a physician's order, dated 4/25/12, indicated Resident #41's Atenolol was to be discontinued. During an interview with LPN #6 on 6/15/12 at 11:26 a.m., she indicated		in-serviced for F329 Guidelines related to this deficiency. The in-services include monitoring of blood pressure/blood sugars documentation and the need to appropriately record actions taken (See Exhibit K) Licensed nurses have been evaluated for Medication Pass by Administrative Nurses. Skills Validations were completed and documented by Administrative Nursing Personel. Failure to comply with the education provided will result in a disciplinary counseling by the immediate nursing supervisor, documented in the personnel record, up to and including termination. Director of Nursing Service/Nursing Administrators/designee to monitor for compliance on a daily basis through record review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** C.Q.I. audits for F329 Medication Administration and Documentation will be completed daily X7, weekly X4, monthly X2 and then on a quarterly basis for 2 quarters. If the threshold of 95%, are not met the results will be reviewed by the CQI committee and an action plan will be developed and implemented. The CQI tool will be monitored by the Director of Nursing Service/Nursing Administrators	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"We always should check the resident's blood pressure prior to giving the med[ication]." 2. The clinical record for Resident # 46 was reviewed on 6/13/12 at 2:30 p.m. Diagnoses for Resident #46 include but are not limited to diabetes mellitus. A physicians order written on 4/30/2012 stated "Accu checks [blood sugar monitoring] ac & HS [before meals and at bed time] during Prednisone therapy." The order for prednisone therapy [prednisone is a steroid medication taken by mouth, and a well known side effect is an increase in blood sugar levels] was written on 4/27/12, the medication therapy ended on 5/14/2012. A facility "Capillary Blood Glucose Monitoring Tool" for the months of April and May, 2012 was reviewed on		and members of the CQI committee including the Medical Director. (See Exhibit L)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/14/12 at 9:00 a.m. Accu check blood sugar results were missing for the dates and times of; 4/30/12 at 9:00 p.m., 5/2/12 at 9:00 p.m., 5/3/12 at 9:00 p.m., 5/6/12 at 9:00 p.m., 5/7/12 at 11:00 a.m., 5/11/12 at 4:00 and 9:00 p.m. and 5/14/12 at 11:00 a.m. During an interview on 6/14/12 at 11:00 a.m., further information was requested from the Assistant Executive Director. (A.E.D.) The Director of Nursing Services, (DNS) indicated some of the missing dates were found, however the dates of 4/3, 5/2, 5/3, 5/6 and 5/14 were not available. A facility policy titled "Blood Glucose Testing" and dated 1/2010 indicated the purpose of blood sugar monitoring was to "evaluate the effectiveness of medications, manage diabetes..." It also indicated the facility is to" verify physician order." 3.1-48(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	06/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE